Medical Assistance Application for the Elderly and Persons with Disabilities

Who can use this application?	This application is for the elderly and persons with disabilities applying for medical assistance. It is not intended to be used for families with children or pregnant women.
Apply faster online	**GO!** Would you rather apply online? Apply faster online at www.applyforKanCare.ks.gov
This form provides us with the information we need to determine eligibility for you and your family. The following are the programs and services you can apply for with this form.	
Medical Assistance	Medical Assistance programs provide medical coverage for the elderly and people with disabilities. Medical coverage may help pay for medical and hospital bills, doctor's visits, medicine, Medicare premiums, in home assistance services and nursing home care.
On page 3 of this application you will be asked to indicate the type of help you want for each member of your household. The definition of each type of coverage is listed below. Please refer to these when answering.	
Working Healthy	This program is for disabled or blind persons between the ages of 16 to 64 who are working. Based on income level, some individuals are required to pay a monthly premium.
Home and Community Based Services (HCBS)	This program is for persons who have a medical need for services in the community which can keep them out of an institution. There are currently 7 different HCBS programs, each with a different set of rules. Based on income level, some individuals are responsible for a portion of the cost of their care.
Nursing Home	This category of coverage is for persons residing in a nursing home or similar facility for a long term stay. Based on income level, some individuals are responsible for a portion of the cost of their care in the facility.
Child in an Institution	This program is for children through the age of 21 years old who are residing in an institution for a long term stay. Based on income level, children on this program may be responsible for a portion of the cost of their care in the facility.
Program of All-Inclusive Care for the Elderly (PACE)	This program is for disabled persons (age 55 years or older) and persons age 65 or older residing in selected counties within the state. Individuals receive long term care coverage through a managed care network. HCBS guidelines apply to individuals living in the community and institutional guidelines apply to those living in a facility. Based on income level, some individuals are responsible for a portion of the cost of their care.
Medicare Savings Program	This program is for people who have Medicare. This program pays the Part B premiums and may also pay Medicare co-payments and deductibles.

Agency Use Only

Outstationed Worker ☐

For help completing this application, call toll free: **1-888-369-4777**

Follow these steps to apply:

- Complete this form to apply. If you need help or have questions, call 1-888-369-4777. Read the questions carefully and answer honestly. If you are applying for someone else, please answer the questions for that person.
- Sign and date this form. Your application is not complete until it is signed.
- Mail, fax or bring this form to your local Department for Children and Families (DCF) office as soon as possible. It may take 45 days before your application is processed.
- An interview is not required, but you may request one.
- A list of items we may need from you is on the last page of this form.

Return this form to:

A. Tell us why you are applying

To help us better meet your needs, tell us why you are applying:

B. Tell us about the Primary Applicant

The Primary Applicant is the person needing medical assistance.

Your Name: (First, Middle, Last)		Other names used:	
Home Address:		Mailing Address (If different):	
City:	State:	City:	State:
County:	Zip:	County:	Zip:
☐ Check here if you don't have a home address. You still need to give a mailing address.			
Home Phone: ( ) —		Work Phone: ( ) —	
I would like to get information about this application by:			
Email: ☐ No ☐ Yes	Email Address:		
Text: ☐ No ☐ Yes	Cell Phone Number: ( ) —		
What language do you speak at home?		What language do you read at home?	

C. Tell us about Yourself and the People in your home

List yourself and all persons in the household. Include those temporarily out of the home and those living in the home even if you are not applying for them. If you have more than 3 people in your home, please attach another sheet of paper and send it with your application.

		Person 1 Yourself	Person 2	Person 3
First Name				
Middle Name				
Last Name				
Maiden Name				
How is this person related to other household members?	Person 1 is my:	*Self – Person1*		
	Person 2 is my:		*Self – Person 2*	
	Person 3 is my:			*Self – Person 3*
Gender		☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of Birth (mm/dd/yyyy)		/ /	/ /	/ /
Marital Status		☐ Never Married ☐ Married ☐ Common-Law ☐ Divorced ☐ Separated ☐ Widowed	☐ Never Married ☐ Married ☐ Common-Law ☐ Divorced ☐ Separated ☐ Widowed	☐ Never Married ☐ Married ☐ Common-Law ☐ Divorced ☐ Separated ☐ Widowed
Does this person live at the same address as you?			☐ No ☐ Yes	☐ No ☐ Yes
If no, list address.				
Has this person lived in a state other than Kansas in the last 3 months?		☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If Yes, when and where?				
Is this person applying for medical assistance?		☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, does this person need any of these special types? (see page 1 for descriptions of programs)		☐ Working Healthy ☐ HCBS ☐ Nursing Home ☐ Child in an Institution ☐ PACE ☐ Medicare Costs ☐ None of these	☐ Working Healthy ☐ HCBS ☐ Nursing Home ☐ Child in an Institution ☐ PACE ☐ Medicare Costs ☐ None of these	☐ Working Healthy ☐ HCBS ☐ Nursing Home ☐ Child in an Institution ☐ PACE ☐ Medicare Costs ☐ None of these
Does this person have a guardian or conservator?		☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
		If yes, complete additional questions on page 14		

Persons 1, 2, and 3 (continued)

Please continue to answer questions about Yourself, Person 2 and Person 3. Write their names on the first line.

	Person 1 Yourself	**Person 2**	**Person 3**
First and Last Name			
We need Social Security Numbers (SSNs) for everyone applying for medical assistance. A SSN is optional for people not applying for medical assistance, but providing a SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with medical assistance. If someone doesn't have a SSN, call 1-800-772-1213 or visit www.socialsecurity.gov			
Social Security #			
U.S. citizen? (required to answer if applying for medical assistance)	☐ No ☐ Yes	☐ No ☐ Yes If no, please see page 5 for more information.	☐ No ☐ Yes
State and Country of birth			
Race (optional) Check all that apply	☐ White ☐ Black ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Vietnamese ☐ Other Asian ☐ Asian Indian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ American Indian or Alaska Native ☐ Other	☐ White ☐ Black ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Vietnamese ☐ Other Asian ☐ Asian Indian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ American Indian or Alaska Native ☐ Other	☐ White ☐ Black ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Vietnamese ☐ Other Asian ☐ Asian Indian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ American Indian or Alaska Native ☐ Other
Ethnicity (optional) If Hispanic/Latino ethnicity, check all that apply	☐ Mexican ☐ Puerto Rican ☐ Mexican American Chicano/a ☐ Cuban ☐ Other	☐ Mexican ☐ Puerto Rican ☐ Mexican American Chicano/a ☐ Cuban ☐ Other	☐ Mexican ☐ Puerto Rican ☐ Mexican American Chicano/a ☐ Cuban ☐ Other
Has this person delivered a baby in the last 3 months?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Did this person have emergency care in the last 3 months to save life, organs, or bodily function?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Does this person need help paying medical bills from the last 3 months (including Medicare premiums)? If yes, please see additional questions on page 5.	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Which of the following best describes this person's current living situation?	☐ Own home ☐ Renting ☐ Live with someone else ☐ Assisted Living ☐ Hospital ☐ Nursing Facility or other institution ☐ Other	☐ Own home ☐ Renting ☐ Live with someone else ☐ Assisted Living ☐ Hospital ☐ Nursing Facility or other institution ☐ Other	☐ Own home ☐ Renting ☐ Live with someone else ☐ Assisted Living ☐ Hospital ☐ Nursing Facility or other institution ☐ Other

Persons 1, 2, and 3 (continued)

Please continue to answer questions about Yourself, Person 2 and Person 3. Write their names on the first line.

	Person 1 Yourself	Person 2	Person 3
First and Last Name			
Is this person living outside of the home?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, why is this person living outside of the home?			
Date expected to return	/ /	/ /	/ /
If in a hospital, nursing facility or other institution, what is the name of the facility?			
Date Admitted	/ /	/ /	/ /
Date of Discharge	/ /	/ /	/ /
Has this person ever been in a hospital or nursing facility for more than 30 days in a row?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, when? (MM/DD/YY through MM/DD/YY)			
Has this person served in the military?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Is this person the spouse or widow of someone who served in the military?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
What is this person's VA file number?			
Does this person pay for medical expenses?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
How much is the expense?	$	$	$
How often?			
Describe the expense:			

Additional Information about the People in your Household

Help with medical bills in the past 3 months Because you have requested help paying medical bills in the past 3 months, please answer these questions.	
Have there been any changes in the household during the last 3 months? (People moving in or out)	☐ No ☐ Yes
If yes, tell us about the household changes:	
Have there been any changes in the household income during the last 3 months?	☐ No ☐ Yes
If yes, tell us about the income changes:	
Have there been any changes in the household assets during the last 3 months?	☐ No ☐ Yes
If yes, tell us about the asset changes:	

Immigration Status: Please provide immigration status for everyone applying who is NOT a U.S. citizen.
(Please note: Applying for KanCare medical assistance does not affect your immigration status.)

Name (First, Middle, Last)	Document Type	Immigration number	Immigration status

Federal Income Tax Information

We have some questions about how you plan to file your taxes. Answer these questions based on your current situation.

	Person 1 Yourself	Person 2	Person 3
First and Last Name			
Based on your current situation, does this person plan to file a federal income tax return?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
	If yes, please answer questions 1 – 3. If no, please skip to question 3		
1. Will this person file jointly with a spouse?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, name of spouse			
2. Does this person have any dependents on their tax return?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, list name(s) of dependents			
3. Is this person claimed as a dependent on someone else's tax return?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, list the name of the tax filer			
How is this person related to the tax filer?			

D. Tell Us if You Are Disabled

We need to know if any persons in your household have a disability. Note: Personal Health Information disclosed here will only be used to determine your disability status and will not be shared with others.

	Person 1 Yourself	Person 2	Person 3
Does this person have a disability that will last at least 12 months or result in death?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Has this person ever applied for Social Security Benefits?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
	If yes, answer the questions below.		
Was the application denied?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, when?			
Is the denial under appeal?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, what is the status?			
Has the existing condition become worse since the Social Security denial?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, explain			
Does this person have a new disability or condition that Social Security did not look at?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, briefly describe the disability.			
Is an attorney or someone else helping this person with the Social Security application for disability benefits?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, list name of the person and organization			
Phone Number of Person or Organization			

E. Tell us about your Resources

We need to know about your resources to decide if you can get benefits.

1. Answer the questions below. Mark No or Yes on each item. If yes, provide details about the resource.

Type of Resource		Name(s) on Resource	Amount or Value	Where is Resource Held? (Name of Bank, Credit Union, or Company)	Account Number
Cash	☐ No ☐ Yes				
Checking Account	☐ No ☐ Yes				
Savings Account	☐ No ☐ Yes				
Certificate of Deposit (CD)	☐ No ☐ Yes				
Retirement Plan	☐ No ☐ Yes				
Nursing Facility Accounts	☐ No ☐ Yes				
Stocks and Bonds	☐ No ☐ Yes				
Funeral or Burial Plans	☐ No ☐ Yes				
Burial Plots	☐ No ☐ Yes				
Other: _____	☐ No ☐ Yes				
Other: _____	☐ No ☐ Yes				

2. Does anyone in your household have a vehicle? ☐ No ☐ Yes If yes, complete the following.

	Vehicle #1	Vehicle #2	Vehicle #3
Year			
Make			
Model			
Owner			
Estimated Value	$	$	$
Balance Owed	$	$	$
Registered in Kansas?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
How do you use the vehicle?			

3. Does anyone in your household have life insurance? ☐ No ☐ Yes If yes, complete the following.
Include copies of all policies.

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value
			$	$
			$	$
			$	$

4. Does anyone in your household own a home? ☐ No ☐ Yes If yes, complete the following.

Owners		Address			
Date Purchased	/ /	Value	$	Amount Owed	$
Who lives in the home?					
If the owner does not live there, explain why:					
If the owner does not live there, does the owner intend to return home?	☐ No ☐ Yes				
If yes, when?					

5. Does anyone in your household own other real estate (including buildings, lots, farm ground, second homes)? ☐ No ☐ Yes If yes, complete the following.

Describe Property					
Is this property used as rental or income producing property?	☐ No ☐ Yes				
Owners		Address			
Date Purchased	/ /	Value	$	Amount Owed:	$

6. Does anyone in your household have a life estate or life interest in any property? ☐ No ☐ Yes
If yes, complete the following.

Describe Property			
Owners		Address	
List date life estate created:	/ /	Value of Property	$

7. Does anyone in your household have a trust? ☐ No ☐ Yes If yes, complete the following.

Type		Owners		Amount	$
Purpose					

8. Does anyone in your household have an annuity or other similar investment, including those issued as part of a retirement package? ☐ No ☐ Yes If yes, complete the following.

Owners		Value	
Company			

Note: For Long Term Care assistance, the State of Kansas must be named as the beneficiary of any annuity you own which was purchased on or after February 8, 2006. More information will be given to you about this process. You agree to make this assignment when you sign the application.

9. Does anyone owe you money through a promissory note or other loans? ☐ No ☐ Yes
If yes, explain _____
_____

10. Does anyone in your household have other assets (such as an R.V., trailers, boats, livestock, oil rights, machinery, etc)? ☐ No ☐ Yes If yes, complete the following.

Describe Asset			
Owners		Value	$
Describe Asset			
Owners		Value	$

11. Have you or your spouse taken a loan against any property in the last five years, including a second mortgage or reverse mortgage? ☐ No ☐ Yes

12. Have you or your spouse ever waived rights to an inheritance or will? ☐ No ☐ Yes

13. Have you or your spouse ever worked with an attorney for Estate Planning purposes?

☐ No ☐ Yes If yes, complete the following.

Name of Attorney		Date	/ /

14. Have you or your spouse sold, traded, given away or changed ownership of any property such as a house or money, or any other property in the last 5 years? ☐ No ☐ Yes If yes, complete the following.

Date Ownership Changed	Type of Property	Value	Given/Sold to	Purpose
/ /		$		
/ /		$		
/ /		$		

F. Tell us about your Earned Income

Does anyone in your household have a job? ☐ No ☐ Yes If yes, answer the questions below.			
	Job 1	Job 2	Job 3
Worker's Name			
Company name			
Company Address			
Company Phone			
Start Date	/ /	/ /	/ /
How many hours working per week?			
Gross Salary or hourly wage	$	$	$
How often are they paid?			
Date of next paycheck?	/ /	/ /	/ /
Do any of these jobs include tips, commissions or bonuses? If yes, answer the questions below.			
	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
What type?			
What is the usual amount? (before deductions)	$	$	$
How often?			

Is anyone in your household self-employed? ☐ No ☐ Yes If yes, answer the questions below.
Self-employed means this person is their own boss. This includes odd jobs, childcare, lawn mowing, snow removal, cosmetic sales, rental income, etc, even if it is not your primary job.

	Self-employed 1	Self-employed 2	Self-employed 3
Name of self-employed person			
Business Name			
What type of business is it?			
When did the business start?			
Were taxes filed on this income last year?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
What IRS form did you file for this income?	☐ Schedule C ☐ Schedule D ☐ Schedule E ☐ Schedule F ☐ 4797 ☐ 1065 ☐ 1120S ☐ Schedule K ☐ Other _____	☐ Schedule C ☐ Schedule D ☐ Schedule E ☐ Schedule F ☐ 4797 ☐ 1065 ☐ 1120S ☐ Schedule K ☐ Other _____	☐ Schedule C ☐ Schedule D ☐ Schedule E ☐ Schedule F ☐ 4797 ☐ 1065 ☐ 1120S ☐ Schedule K ☐ Other _____
Reported Annual Gross Income	$	$	$
Reported Annual Gross Expenses	$	$	$
Estimated monthly income (before expenses)	$	$	$
Monthly expenses	$	$	$

Tell us about your Work Expenses

If you are disabled and working, list any expenses related to your disability which allow you to work. Examples: specialized transportation to and from work, attendant care at work or to help you get ready for work, service animals, medications, specialized equipment or tools.

	Person 1 Yourself		**Person 2**		**Person 3**	
Does this person have income from working?	☐ No ☐ Yes		☐ No ☐ Yes		☐ No ☐ Yes	
If yes, list any expenses related to your disability which allows you to work.	Type of Expense	Monthly Amount	Type of Expense	Monthly Amount	Type of Expense	Monthly Amount
		$		$		$
		$		$		$
		$		$		$

G. Tell us about your Other Income

Complete the following chart. Mark no or yes on each item below.

Type/Source of Income		Name of Person who receives this	Amount Received	How Often Received	Claim No.
Social Security Benefits	☐ No ☐ Yes		$		
Supplemental Security Income (SSI)	☐ No ☐ Yes		$		
Veteran's Benefits	☐ No ☐ Yes		$		
Railroad Retirement	☐ No ☐ Yes		$		
Trust Payments	☐ No ☐ Yes		$		
Annuity Payments	☐ No ☐ Yes		$		
Other Retirement or Pension Source _____	☐ No ☐ Yes		$		
Worker's Compensation	☐ No ☐ Yes		$		
Unemployment	☐ No ☐ Yes		$		
Tribal Payments	☐ No ☐ Yes		$		
Oil Royalties/ Mineral Rights	☐ No ☐ Yes		$		
Contract Sale	☐ No ☐ Yes		$		
Rental Income	☐ No ☐ Yes		$		
Child Support	☐ No ☐ Yes		$		
Spousal Support	☐ No ☐ Yes		$		
Other Income Source 1 _____	☐ No ☐ Yes		$		
Other Income Source 2 _____	☐ No ☐ Yes		$		

H. Tell us about your Medical Insurance

Health Insurance Policy Information Answer the questions below for everyone who has Medicare or other health insurance			
	Person 1 Yourself	Person 2	Person 3
First and Last Name			
Does this person have Medicare? If yes, answer the questions below	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Medicare Claim #			
Medicare Part A?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Part A Effective Date	/ /	/ /	/ /
Part A Premium Amount	$	$	$
Medicare Part B?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Part B Effective Date	/ /	/ /	/ /
Part B Premium Amount	$	$	$
Medicare Part C? (Medicare Advantage)	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Part C Effective Date	/ /	/ /	/ /
Part C Premium Amount	$	$	$
Part C Plan Name			
Medicare Part D?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Part D Effective Date	/ /	/ /	/ /
Part D Premium Amount	$	$	$
Part D Plan Name			
Answer the questions below for everyone who has insurance OTHER than Medicare.			
Does this person have other health insurance?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Policyholder's name			
Policyholder's SSN			
Insurance Company Name			
Insurance Company Address			
Date Began	/ /	/ /	/ /
Date Ended	/ /	/ /	/ /
Policy #			
Group #			
Type of Coverage	☐ Catastrophic Only ☐ Dental ☐ Doctor ☐ Hospital ☐ Long Term Care ☐ Medicare Supplement ☐ Prescription ☐ Vision ☐ Other _____	☐ Catastrophic Only ☐ Dental ☐ Doctor ☐ Hospital ☐ Long Term Care ☐ Medicare Supplement ☐ Prescription ☐ Vision ☐ Other _____	☐ Catastrophic Only ☐ Dental ☐ Doctor ☐ Hospital ☐ Long Term Care ☐ Medicare Supplement ☐ Prescription ☐ Vision ☐ Other _____

I. Tell Us About Your Dependents and Household Expenses

Complete this section only if applying for HCBS or institutional care. You may be able to protect a portion or all of your own income for your dependents. If you have a spouse or minor child that is part of your household that you have not already told us about, go back to **Section C** and answer the questions.

Dependents

If you have minor children that don't live with you or you have another family member who is dependent on you, please complete the following:

Name of Individual	Relationship to you	Date of Birth	Individual's monthly income	If a child, who does the child live with?	If a child and living with another parent, list the monthly income of the parent
		/ /	$		$
		/ /	$		$
		/ /	$		$

Household Expense

List monthly shelter expenses below for the spouse at home.

	Type of Expense	How Often?	Amount
1	Rental Cost / Lot Rent		$
2	Mortgage Payment		$
3	Property Taxes (if not included in #2 above)		$
4	Home Insurance (if not included in #2 above)		$
5	Other (Condominium/Home Owners Association fees)		$

Choose Your Health Plan

If approved for Kansas medical assistance, your services will be provided by KanCare. There are 3 KanCare health plans to choose from. Please review the Extra Services Highlights and choose your plan. If you do not choose, a plan will be assigned for you. If you do not like your assignment, you will have 90 days to change plans. You will receive a packet of information about your plan. For more information about these plans, visit www.KanCare.ks.gov

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J. Choose Someone to Help You With Your Medical Assistance Case

Primary Applicant - If you are completing this application on behalf of someone for whom you are the Guardian, Conservator, Financial Power of Attorney or Social Security Payee, please complete the information below and submit proof.

First and Last Name					
Address Line 1					
Address Line 2					
City		State		Zip Code	
Phone Number		Email Address			

You can name a person to help you with your medical assistance case. You can choose either a "Medical Representative" or a "Facilitator."

Medical Representative is a person who can sign your application, answer questions for you, and use your medical assistance card for you. We will share information with this person. This person will get copies of letters sent to you about your case. This person is responsible for completing your review each year and for telling us about changes in your situation. The Medical Representative can be a relative, neighbor, friend, or other person you trust. You may not name someone who is trying to collect a medical debt against you.

Facilitator is a person who can help you fill out your application and help you through the application process. We will be able to share information with this person. This person will get copies of letters sent to you about your application. After your application is processed, this person is not connected to your case. A facilitator can be someone such as a relative, neighbor, friend, medical office staff, or community organization employee.

I want to appoint the following person to help me.

First and Last Name					
Organization Name					
Address Line 1					
Address Line 2					
City		State		Zip Code	
Phone Number		Email Address			
What is this person's relationship to you? (for example: child, friend, neighbor, etc)					

I appoint the above named person to be my ☐ Medical Representative, or
☐ Facilitator.

Signature		Date	

Witness signatures are required if the signature above is made with a mark.

Witness		Date	
Witness		Date	

K. Signature Page

You must sign and date this form before you send it back. **If this form is not signed, it will be returned to you.** This will cause a delay in processing your application. **Read the information below. Sign and Date.**

I understand:

- I have the right to equal treatment regardless of race, color, sex, age, disability, religion, political belief, or national origin.
- I have the right to have information I have provided kept confidential unless directly related to the administration of Kansas medical assistance programs.
- I have to provide or apply for a Social Security number for anyone who is applying for health benefits and I authorize use of these numbers to administer the program. These numbers will also be used for computer matches with other organizations such as banks, the Social Security Administration, and Internal Revenue Service.
- It is important to provide current income, address, and household composition information, and I am responsible for reporting changes during the application process and while eligible.
- Some or all of the people for whom I am applying may receive similar health coverage under the Medicaid program if eligible.
- I have the responsibility to use and report any third-party resources (such as health insurance, court settlements, medical support payments, trusts, conservatorships, etc.) that may have a legal obligation to pay any or all of the medical expense of those for whom I am applying. I understand that payment for a particular service may be withheld while a determination of failure to use a third-party resource is made.
- Any payments made to me by a third-party resource for medical services covered under Kansas medical assistance programs will be used to pay for the applicable medical bills and that these programs will only pay for services not covered by that third-party resource. I agree to cooperate with the medical subrogation unit in pursuing those third-party resources.
- If I receive medical assistance after age 54 or while in an institutional arrangement, there may be a claim against my estate to recover the medical expenditures made on my behalf. I understand that my financial institution(s) will be notified of a pending claim.
- I have the responsibility to read and truthfully answer all the questions on this application. I understand that if I provide false or purposefully misleading information on this application or hide information requested by the application, I will be subject to penalties for my actions.
- I have the right to request a fair hearing if I disagree with a decision. A written request must be made within 30 days of the decision.

I agree:

- To turn over any medical support payments for all persons receiving medical assistance if adults in the household are determined eligible for medical assistance.
- To help Child Support Services (CSS) in establishing and enforcing support orders (if needed) if adults in the household are determined eligible for medical assistance.
- To pay the Working Healthy premium each month if I qualify for that program. The premium may be as little as $0 or as much as $152 depending on my income.

I certify:

- That everyone I am requesting health coverage for – and who is determined eligible for such coverage – is a U.S. citizen or is a non-U.S. citizen in lawful immigration status. Proof of immigration status may be required. (Exception: persons applying for emergency medical assistance under SOBRA)
- Under penalty of perjury, that my answers are correct and complete to the best of my knowledge.

I authorize:

- Payments under this program to be made directly to the physicians and other medical providers, or managed care organizations for covered medical and other health services furnished to those for whom I am applying who are eligible.
- Medical providers to release medical information to the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE DHCF), the Department for Children and Families (DCF), the Kansas Department for Aging and Disability Services (KDADS), the U.S. Department of Health and Human Services, insurance companies, and other contracted medical providers. I also authorize KDHE, DCF, and KDADS to share medical information for administrative purposes with other agencies and contractors.
- Employers, medical providers, financial institutions, insurance providers, benefit providers, and other persons or agencies with knowledge of my circumstances, to release to KDHE, DCF, KDADS, or other benefit programs, any information including financial and other confidential information necessary to establish my eligibility.

My signature on this application signifies that I have read and understand the conditions above. All information provided on this application is protected by state and federal confidentiality laws. This release is valid from this date. A copy of this authorization is as valid as the original.

Signature of Applicant (required)	Date
Signature of Other Adult Applying	Date
Signature of First Witness (if "X" is used)	Date
Signature of Second Witness (if "X" is used)	Date
Signature of Medical Representative (if applicable)	Date

FOR AGENCY USE ONLY:

Would you like to register to vote today?

No _____ Yes _____ Already registered _____

For help completing this application, call toll free: **1-888-369-4777**

Information You May Have to Provide

When you submit this application form you need to send proof of certain things. Please review this list carefully and send the required proof with your application form. By sending all of the required proof, your application can be processed more quickly.

Proof of Income

If you are reporting that you have a job
We may need copies of your paystubs for the last 30 days, or a statement from your employer with your gross income (before deductions.)

If you are reporting that you are self-employed
You must send your most recent personal and business income tax returns, including all pages and attachments.

If you are reporting that you have other income
We may need a copy of the check or benefit letter that shows the amount of income you get and how often you get the payment.

If you have unpaid medical bills from the past 3 months and would like help
We may need copies of all paystubs or checks your family has received in the past 3 months.

Proof of Resources

If you are reporting that you have a checking account, savings account, stocks/bonds or CDs
You must send a copy of your most recent bank statement.

If you are reporting a Funeral or Burial Plan
You must send a copy of the plan.

If you are reporting a Trust or Annuity
You must send a copy of the trust or annuity.

If you are reporting life insurance
You must send a copy of the life insurance policy.

If you are reporting ANY resources, proof must be sent to us.

Proof of Health Insurance

If you are reporting that someone in the household has other health insurance
We may need a copy of the front and back of your health insurance card. You also must send a bill that shows how much you pay for the insurance.

✓ Did you remember to:

- ☐ Fill everything out?
- ☐ Tell us about everyone in your family and household, even if they don't need medical assistance?
- ☐ Sign this application on page 15?